apogee insurance group
A Berkshire Hathaway Company

DENTISTS PROFESSIONAL LIABILITY APPLICATION (CLAIMS MADE COVERAGE)

1) Full Name of Applicant: Degree:

2) Principal Practice Address:

3) Additional Practice Locations:

4) Home Address:

5) Website Address

6) Social Security #: 7) DEA#

8) Date of Birth: 9) Place of Birth:

10) Are you a U.S. Citizen? YES NO

If NO, please indicate your status and date of entry into the United States:

11) From what Dental School did you graduate?

City, State and Country of Dental School

Degree: Year of Graduation:

If foreign medical school graduate, provide the date you began your practice in the United States:

12) Provide a detailed summary of where you have practiced since completing your training:

Address/City/State	Country	From	To

13) Indicate memberships in professional societies:

14) List the States and License numbers where you practice.

15) Type of Practice (Check all that apply)

☐ Individual ☐ Employee ☐ Member of Multi-person Corp or Assoc*

☐ Individual Corporation * ☐ Partnership

Other

* Specify name of entity:

16) Do you want coverage for the entity named above? ◯ YES ◯ NO

17) If you practice other than as an employee, unincorporated solo practitioner or independent contractor, please list the names of all dentists or oral surgeons practicing under the entity named above.

18) Do you practice with any dentists not named above? ◯ YES ◯ NO

If yes, provide the name of the dentists(s) and relationship to your practice:

19) Please provide the names of all facilities that you practice at and your interest in each facility.

Name of Clinic or Facility and Location	Interest (Owner, Partner, Employee)

20) Are you seeking coverage for your work at all of the above facilities? ◯ YES ◯ NO

If No, please list those facilities for which you do not require coverage and explain why coverage is not needed.

21) Please provide the number of professionals you employ or contract with and whether or not they carry their own individual medical malpractice coverage.

	# Employed	# Contracted	Carry their own Med Mal policy?
Dentists (other than yourself)			YES NO
Dental Assistants			YES NO
Dental Technicians			YES NO
Hygienists			YES NO
Nurse Anesthetists			YES NO
Anesthesiologists			YES NO
Other:			YES NO

Provide a description of duties, in detail, including extent supervised on separate page and attach protocols.

Please attach copies of dec pages on above professionals that carry their own malpractice policies.

22) Are all of the above individuals licensed in accordance with applicable state and federal regulations? YES NO

If No, please provide detailed explanation below.

23) a. What is your dental specialty?

b. Do you limit your practice to the above specialty? YES NO

If No, provide details:

24) Are you American Dental Board certified in any speciality? YES NO

If Yes, provide the Board(s) in which you are certified:

Year:

25) What is your total annual revenue?

- ☐ $100,000 or less
- ☐ $100,001 - $250,000
- ☐ $250,000 - $499,999
- ☐ $500,000 or more

26) Average weekly patient load:

27) Average number of hours you practice each week:

28) Please provide the approximate percentage of your practice in the following:

- Bone Grafting
- Cosmetic Dentistry
  - Bonding
  - Enamel Shaping
  - Full Mouth Restoration- Cosmetic Only
  - Veneers
  - Whitening with lasers

28) Continued

Other Cosmetic Procedures (describe below)

Endodontics

- Single Rooted
- Multi Rooted
- Sargenti Root Canal Method

General Denistry

- Extractions of Impacted Teeth
- Root Canal
- Simple Extractions Only

Implants

- Restoration
- Placement

Microneurosurgical Procedures

- Oral Pathology
- Oral Radiology
- Orthodontics
- Orthognathic Procedures
- Pediatric Dentistry
- Periodontics
- Prosthodontics

Non-Dental Cosmetic Procedures (including injecting Botox, collagen and fillers) (describe)

Prosthetics

- Fixed
- Removable

Sleep Apnea

- Surgery
- Therapy

Surgery

- Facial - Elective Cosmetic
- Head and Neck
- Oral/maxillofacial
- Outside oral/maxillofacial region

* Please provide a complete list of all surgical procedures performed below.

TMJ

- Non-surgical
- Surgery

Other (describe)

Total 100%

*List of Surgical Procedures:

29) Do you use written informed consent documents for all procedures? ◯ YES ◯ NO

If Yes, attach a copy of all forms that are used. If No, describe below.

30) Do you wire jaws closed for purposes of weight loss? ◯ YES ◯ NO

If Yes,

a) Number performed in the last 12 months

b) Estimated number that will be performed in the coming year

31) What percentage of your patients are under age 18?

32) Do you perform any hospital emergency room care? ◯ YES ◯ NO

If Yes, is this solely a requirement for active admitting privileges? ◯ YES ◯ NO

If No, provide a detailed description including the approximate number of hours per month spent in emergency room care.

33) If you perform any of the following procedures, check all that apply. For each procedure performed indicate where the procedure is performed. (H= Hospital ; O = Office ; S = Surgi-Center or Certified Surgical Suite)

	Location		Location
☐ Acupuncture		☐ Cheek Implant	
☐ Adenoidectomy/Tonsillectomy		☐ Chemical Peel	
Anesthesia:		Solution Strength (specify)	
☐ General		☐ Chin Surgery	
☐ Twilight		☐ Cleft Lip and Palate Surgery	
☐ Other-(describe)		☐ Cosmetic implantation of silicone or other material	
☐ Oral/Maxillofacial Surgery		☐ Cosmetic Surgery	
☐ Other Surgery(describe)		☐ Cryosurgery	
Extractions:		☐ Dental Alveolar Surgery	
☐ Non-Impacted Teeth		☐ Dermabrasion/Microdermabrasion	
☐ Impacted Teeth		☐ Dermal Fillers	
Surgery and Other Procedures:		☐ Face Lift	
☐ Biopsies (describe)		☐ Hair Transplants or Suture of Hairpieces	
☐ Blepharoplasty		☐ Laser Skin Resurfacing	
☐ Botox Injections			

Surgery and Other Procedures (Continued)

- ☐ Laser Surgery (describe)
- ☐ Liposuction - above the neck (specify volume)
- ☐ Liposuction - below the neck:
  - ☐ under 3500 cc's volume
  - ☐ 3500 cc's or more volume
- ☐ Nerve Grafts
- ☐ Open Reduction of Fractures
- ☐ Pain Management (describe)
- ☐ Radiation Therapy
- ☐ Radiopaque dye injections into blood vessels, lymphatics, sinus tracts or fistulae
- ☐ Reconstructive Plastic Surgery (describe)
- ☐ Rhinoplasty
- ☐ Sargenti Root Canal Method
- ☐ Sinus Lift
- ☐ TMJ Surgery
- ☐ Uvulopalatroplasty

34) Is analgesia, sedation or anesthesia used on patients? ◯ YES ◯ NO

If Yes, do you administer Local Anesthesia ONLY? ◯ YES ◯ NO

If Local Anesthesia only, please continue to Q. 35.

If No, and you administer other types of anesthesia, PLEASE COMPLETE DENTIST'S ANESTHESIA SUPPLEMENTAL

35) Have you or any of your employees: ◯ YES ◯ NO

A. Ever been the subject of investigative or disciplinary proceedings or reprimanded by a governmental or administrative agency, hospital, or professional association? ◯ YES ◯ NO

Attach a copy of Complaint and Consent order document if applicable.

B. Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ◯ YES ◯ NO

C. Ever been treated for alcoholism or drug addiction or undergone personal psychiatric treatment or has any administrative agency, hospital or professional association requested or required you to be evaluated for an alleged mental condition and/or alcohol or drug addiction? ◯ YES ◯ NO

D. Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked renewal refused or accepted only on special terms or ever voluntarily surrendered same? ◯ YES ◯ NO

E. Ever had any professional liability insurance cancelled, declined, refused to renew or accepted only on special terms? ◯ YES ◯ NO

F. Ever failed any medical licensing or specialty organization examination? ◯ YES ◯ NO

G. Do you have any chronic illnesses or defects? ◯ YES ◯ NO

If Yes to any of the above questions, please provide full details below.

36) Do you anticipate any changes in your practice? ◯ YES ◯ NO

If Yes, please describe below.

37) List the prior medical malpractice insurance carried for each of the past 5 years beginning with most current:

Insurance Company	Limits Of Liability	Policy Period	Premium	Retro Date

* Attach a copy of the declarations page of your most recent policy.

38) Do you own, operate or provide professional services for, or at, any dental or health care facility or business enterprise not already clearly described in this application? ◯ YES ◯ NO

If Yes, please describe:

39) Has any claim or suit for alleged malpractice been brought against you? ◯ YES ◯ NO

If Yes, how many total claims or incidents:

Please complete the Supplemental Claim Information Form for this application for each and every claim. Also please attach 10 years of currently valued company loss runs.

40) Has any claim or suit for alleged malpractice been made against you that has NOT been reported to a prior insurer? ◯ YES ◯ NO

If Yes, Please complete the Supplemental Claim Information Form for this application for each and every claim.

41) Are you aware of any acts, errors, omissions or circumstances which may result in a malpractice claim or suit being made or brought against you? ◯ YES ◯ NO

If Yes, please include details including name of claimant, date of occurrence, date of first contact, allegation and current status of incident.

☑ I/We declare that I/we have reviewed this Application for accuracy before signing it, that the above statements and representations are true and correct, and that no facts have been suppressed or misstated. I/We understand that this is an application for insurance only and that the completion and submission of this Application does not bind the Company to sell nor the applicant to purchase this insurance. I/We nevertheless acknowledge that any contract of insurance issued by the Company in response to this Application will be in full reliance upon the statements and representations made in this Application and that this Application will be made part of the policy. I/We understand that any contract of insurance issued by the Company in response to this Application will be issued on a claims made form.

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance, or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/we agree that this Application shall be the basis for any contract of insurance issued by the Company in response to it.

Electronic Signature of Applicant or Authorized Representative:

Current Date:

Title

If you prefer not to Return Application with an Electronic Signature, Please print and Sign Below:

The applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this electronically submitted application does not bind the Company to sell nor the applicant to purchase this insurance, but any subsequent contract issued will be in full reliance upon the statements and representations made in this electronic application and this application will be made part of the policy. The applicant understands that any subsequent contract issued by the Company will be issued on a claims made form.

Signature of Applicant or Authorized Representative

Current Date:

Title

Please attach copies of the following documents:

- CV or Resume
- Five years of currently valued company loss runs
- Copies of any disciplinary actions, stipulations orders or probation documents
- Copies of declaration pages for all employees or contractors that carry their own med mal
- Copy of applicant's most current declarations page

Additional Comments or Details: